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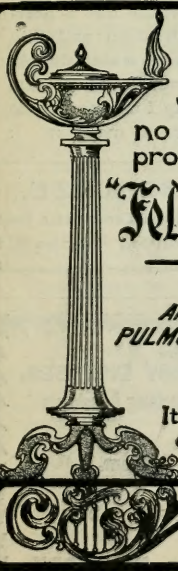

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The Maritime Medical News

Vol. xxi., *OCTOBER, 1909*, No. 10.

WORLD OF MEDICINE.

Lumbar Puncture

The therapeutic value of Lumbar Puncture in cases of cranial injury is well brought out by Savy in a case reported by him in *Le Lyon Chirurgical*. The patient was brought into hospital unconscious after a fall from a height. The appearance, a day or two later, of a subconjunctival hæmorrhage, led to the diagnosis of a fracture of the basis cranii; but no surgical interference was deemed advisable in view of the progressive amelioration of the condition of the patient, who took his discharge from hospital five weeks after the accident. It was not until three months later that the patient experienced further symptoms, consisting of weakness and rigidity of the lower limbs accompanied by constant headache. After a few weeks in bed, the patient was readmited to hospital with characteristic meningeal symptoms — headache, sickness, constipation, delirium, a fluctuating temperature, and a well-marked Kernig's sign. In addition he complained of pain along the course of both sciatic nerves. Lumbar puncture was performed, and a collection of black, tarry blood was evacuated drop by drop. No improvement followed this first puncture, but a second and a third led to improvement. No blood or cerebro-spinal fluid was obtained at a fourth operation. The interest of the case lies in the long duration of the latent period between the accident and the onset of symptoms, and in the possibility of evacuating a still-fluid effusion from the cord so long after its production there. The author is of opinion, in view of this result, that lumbar puncture should be tried in all cases where more or less definite nervous manifestations follow a cranial injury, even when a marked interval of time has elapsed between the injury and the onset of symptoms.—*Hospital.*

* * *

Vaccinal Eruptions

There are several eruptions, such, for example, as eczema and Lichen urticatus, which are often wrongly put down by parents to the effects of vaccination. There are, however, certain forms of erythematous eruption which may be correctly ascribed to this cause; but they are not of common occurrence, and they are for the most part transitory and harmless. They may be regarded as analogous to similar eruptions which may occur as the result of the administration of certain drugs, or of serum or vaccines, or from absorption of food poisons. They may be scarlatinform in type, morbilliform, roseolous, urticarial, or mainly limited to the limbs and simulating erythema multiforme. The erythematous eruption is often more intense on the limb about the vaccination sores, and thus may suggest erysipelas; but the presence of a less in-

tense eruption on the trunk and limbs negatives this diagnosis. These eruptions usually appear while the vaccine pustules are at their acme, and subside in the course of a few days. There is a second group of eruptions which may complicate vaccination, all of which are to be avoided if proper precautions are taken. The infection of impetigo, of erysipelas, or even of syphilis might be introduced at the time of inoculation, but with calf-lymph and with antiseptic precautions these complications may be said not to occur at the present time. After the vaccination pustules have developed, there is again opportunity for infection with pus-organisms, and impetigo or erysipelas do sometimes develop, though usually only among the very poor. An accident which sometimes happens, though rarely, is re-inoculation of vaccine at a different site. This is possible up to the ninth or tenth day after vaccination. Instances of re-inoculation have been recorded on the lesions of eczema, of varicella, of herpes zoster, and of impetigo. Accidental inoculation of a parent or nurse, often on the face, is not very uncommon. Possibly some of the cases of so-called generalised vaccinia may have been instances of re-inoculation.—*Hospital.*

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The Rational Puerperium

As long as the year 1773 White of Manchester urged that women should be allowed to get up early after their confinements. 1899 Kustner revived this idea and recommended that puerperal women should be encouraged to get out of bed during the first few days of the puerperium. In a paper recently read before the Edinburgh Obstetrical Society, Dr. F. W. N. Haultain, from an experience of 100 cases, put forward a plea for what he termed the rational treatment of the puerperium. The mode of management which he recommended was that the woman be encouraged to sit up in bed to meals on the second day, and subsequently as soon as she felt inclined that she be allowed to leave her bed and sit up for an hour. On the third and fourth day two hours were to be spent out of bed morning and evening, and the fifth day was to be practically spent out of bed altogether with the exception of a few hours' rest in the afternoon. Under this treatment his patients left the hospital on the tenth day. Of 100 cases treated in this way the morbidity (i. e., of which a temperature over 100° F. or a pulse-rate of over 90 for 12 consecutive hours were taken as the signs) was represented by three. Examination on the day of leaving the hospital showed the pelvic organs to be normal except in two cases where a slight retroversion of the uterus was found. In 48 of the cases examined six weeks or later involution was good, and the position of the uterus was normal except in the two cases mentioned. Dr. Haultain maintains that labour is not a disease and that the puerperium cannot be considered convalescence. He believes that involution is influenced mainly by the circulation, and exercise of the abdominal muscles will improve their tone, accelerate the abdomianl circulation, and among other advantages diminish constipation. The position of the patient can have but little influence on the occurrence of septic inflammation or upon involution, and the erect posture is less likely to produce displacement of the uterus than the dorsal position. In the same way he thinks that early rising will tend rather to diminish than to increase

the chances of the occurrence of phlebitis and embolism. The blood of a puerperal woman is highly fibrinous, and to prevent coagulation the circulation should be stimulated, and this is most readily done by muscular exevtion. Most of the speakers who took part in the discussion at Edinburgh were not entirely convinced by the arguments brought forward. The danger of backward displacements was thought to be considerably greater than the figures quoted in the paper showed, and Dr. J. W. Ballantyne pointed out that among the Javanese, who were compelled by custom to rise for a short time during the first day and move about the house, prolapse was exceedingly common and embolism frequent. Although it may be true, as Dr. Haultain maintains, that the normal puerperium is not a convalescence from disease yet it may well be regarded as a convalescence from the troubles and often marked trials of pregnancy. Further than this, in a large majority of women the rest in bed, even it it be only for ten days, has a most beneficial effect upon their general health. That it is possible without any serious risk of injury to make a woman get up on the first few days following her confinement is quite true, but that it is expedient is very doubtful. We grant that fortunate results may be met with in a small series of cases, such as those recorded by Dr. Haultain, but the adoption of this method of treatment on the large scale would, we feel sure, lead to a number of undesirable complications. It is interesting to have a scientific confirmation of the fact that women can get up within a short time of their confinements and suffer no harm, as indeed a great many among the poor do at the present time, but we do not think that it has been proved that such a procedure is desirable for the majority.—*Lancet.*

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Strophanthus, Digitalis and Nitrites in Heart Disease

Digitalis is by far the most powerful of the drugs in ordinary use for diseases of the heart, and in the light of the newest teaching in regard to the physiological principles to be followed in medical treatment, especially concerning cardiac rhythm, further scientific investigation is needed. In unsuitable cases, digitalis may cause deplorable results, for, besides its action on the heart, this drug has a pronounced effect upon the blood-vessels, causing vaso-constriction, and, therefore, a rise of blood-pressure. Dr. Langdon Brown puts the whole case very well when he says, in his teaching on physiological principles in treatment, that it is to be hoped that in time it will be generally realised that it is as rash to give digitalis without thinking of the blood-pressure as it is to give morphia without examining the urine. There is no doubt that at present digitalis is prescribed frequently for a heart that is failing behind a pressure that is already excessive, the fact being overlooked that the administration of strophanthus is preferable if the blood-pressure be distinctly raised, for this drug has a similar cardiac effect to digitalis, but a much smaller vascular one. Supposing, however, that a medical man persists still in using digitalis in such a case, then he should remember that a nitrite must be given also, so as to act as a vaso-dilator. It has been clearly shown by Cushny that in such a case the best results are secured by frequent small doses of nitro-glycerine, which need not be administered for some hours after the digitalis; the reason for this is that the action

of digitalis sets in rather slowly, and persists for a long time, whilst nitrites act rapidly, but are excreted comparatively soon. It is worth nothing, incidentally, that, in the experience of Dr. Langdon Brown, of all drugs in the treatment of heart-block, strychnine yielded him the most striking beneficial results, and the improvement followed its exhibition so frequently and so speedily that the benefit cannot be regarded as a mere coincidence.—*Practitioner.*

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The Sugar Test of Water Purity

It is sometimes useful to be able to obtain an idea of the purity or otherwise of a given water supply without incurring the expense of a full chemical and bacteriological analysis. Among the constituents of sewage are phosphates in comparative abundance. If a clear-glass bottle is nearly filled with the water to be tested, a lump or two of sugar added, and the whole corked tightly and placed in a sunny place for two or three days, the water should remain quite clear. If, however, it contains phosphates in excess, a milkiness will have developed in it, in which case the suspicion of contamination would be sufficiently confirmed to warrant a full analysis of the water supply before any more of it was used for drinking purposes.—*Exchange.*

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Causes of Arterio-sclerosis

Huchard (*Journ. des prat.*, May 22nd, 1909), out of a very large number of cases of arterio-sclerosis, deduces the following as the principal causes in their order of frequency: Gout, rheumatism, syphilis, dietetic causes, tobacco, infectious diseases, diabetes, alcohol, malaria, the menopause, and moral and nervous causes. According to Ambard and Beaujard, retention of chlorides is a factor in the production of arterio-sclerosis, and heredity may also play a part, as admitted by Broadbent. Sometimes also hereditary gout and hereditary syphilis may act as causes. There is no proof that arterior-sclerosis is of suprarenal origin. Naturally several of these possible causes may be found to occur together, and it is especially when two or more are combined, and particularly when a predisposing cause is present, that arterio-sclerosis is likely to develop. For example, gout and diabetes may occur in a patient of an arthritic diathesis, and those three factors may give rise to the development of arterio-sclerosis. Excessive intellectual work, the author believes, may give rise to arterio-sclerosis, also mental worry, and violent and repeated mental emotions. On many of these causes, as the author points out, one has no control and they cannot be prevented from exerting their baneful effect; some of them however, can be dealt with, particularly by dietetic and hygienic measures.

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Secret Remedies

The volume entitled *Secret Remedies: What They Cost and What They Contain*, which has just been published by the British Medical Association, will, there can be no doubt, prove very useful to medical practitioners, who often find their patients taking nostrums, and are sometimes even asked to sanction their employment. The volume is based on analyses made for the British Medical Association and published from time to time in the *British Medical Journal* during the last few years. The secret

remedies examined include the majority of the preparations, commonly, but incorrectly, called patent medicines, which are at present being largely advertised in this country. They are classified in twenty chapters according to the kind of disorder for the cure of which each is more particularly vaunted. The claims made by some of the proprietors are so extensive that it has not always been easy to assign its proper place to the nostrum under examination, but the index of names and ingredients will facilitate reference. Probably the fact that will most strike a medical reader who turns the pages of the volume will be the exceedingly common place nature of the ingredients in all or nearly all the nostrums examined. In some instances, indeed, it is difficult to see how the combination can have any medicinal action whatever unless it be on the principle expounded by the great inventor of Tono Bungay to his nephew, who had asked: "You don't mean to say you "think doing this stuff up in bottles "and swearing it's the quintessence of "strength and making poor devils "buy it at that, is straight?" "Why "not, George? How de we know it "mayn't be the quintessence to them "so far as they're concerned? There's "Faith. You put Faith in 'em. . . . "I grant our labels are a bit empha- "tic. Christian Science, really. No "good setting people against the "medicine." The new volume may, indeed, be described as a kind of appendix to Tono Bungay, containing data justifying the picture which Mr. Wells has drawn with so much skill and humour of Uncle Ponderevo's proceedings in concocting and booming his "science of vigour."—*B. M. Journal.*

EDITORIAL.

HALIFAX AND NOVA SCOTIA BRANCH B. M. A.

THE Halifax and Nova Scotia Branch of the British Medical Association began the 23rd annual session by a meeting held on the evening of September 15th inst., at which officers were elected for the incoming year and arrangements made for a series of meetings during the autumn and winter.

The following officers were elected:
President—J. R. Corston, M. D.
Vice-President—M. A. McAulay.
Treasurer—A. F. Buckley, M. D.
Secretary—K. J. MacKenzie, M. D.
Council—Drs. A. I. Mader, A. Birt, J. J. Doyle, M. A. MacAulay, D. C. Watson, and W. D. Finn.

The meetings of last year were profitable and well attended—perhaps better than for some years and the newly appointed managers will have to be energetic to surpass the record made by the out-going officials. Dr. Doyle, the retiring president, proved to be a capable and courteous presiding officer. The handsome surplus in possession of the Society is the best testimony of the valuable services rendered by the late treasurer, Dr. G. M. Campbell, who served in that capacity for many years. It is a matter of general regret that the condition of Dr. Watson's health would not permit him to coontinue his work as Secretary. The careful and painstaking manner in which he discharg-

ed his duties was recognized by every member, and his retirement is felt to be a distinct loss to the Society.

Last year there were fifteen regular and three special meetings, the average attendance being about 17.8. The proceedings were terminated by a banquet which turned out very successfully. Important communications were sent to the Halifax Board of Health, and an active part was taken in the inauguration of the anti-tuberculosis campaign. The membership although creditable is not up to the mark in point of numbers. A local Society should include every medical man in the community.

Doctors as a class are widely respected and enjoy opportunities for rendering many valuable services to the public. Individual effort may and does do good, but the best results are attained by concentration of forces. Isolation means diversity of interests, or what is more frequent, a total lack of interest. Working together shoulder to shoulder having common purposes and ideals creates congeniality, interest and enthusiasm. An active well regulated Society can make the member a far better doctor, increase his income and lighten and sweeten his work. By papers and discussions, lectures, clinical meetings, establishment of reading rooms, a medical society can aid its members to improve themselves.

A fair and just tariff of fees can only be secured by united effort. A Society well supported ought to be able to eliminate petty jealousies and dissensions. To the laity the Society can be of great service. When an organization exists whether in city, town or country, it should be through its officers the recognized authority on all matters of sanitation and hygiene. If the Society acts wisely, cautiously and fairly, its right to settle all of these questions will soon be recognized.

It is hard to conceive how doctors knowing the possibilities of fellowship for social, financial and professional improvement, and ethical development attainable in a well conducted Society would be willing to deny themselves the benefits.

Doctors should be broad-minded enough to lay aside differences and work together.

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DIAGNOSIS OF PULMONARY TUBERCULOSIS BY LOCAL USE OF TUBERCULIN.

IT is now very generally recognized that pulmonary tuberculosis is curable in the early stages in quite a large percentage of cases. The laity, through the educational efforts of anti-tuberculosis leagues, are becoming daily more impressed with the same idea, and also more disposed to be critical about the methods adopted by physicians to recognize the malady at its onset. Early diagnosis is therefore of the utmost importance. Unfortunately the ordinary methods of diagnosis—a carefully prepared clinical history—a thorough physical examination of the chest, and repeated examinations of the sputum when present for tubercle bacilli quite frequently only yield doubtful evidence. The X-ray examination of the chest, blood examination, opsonic tests, and the examination of the cellular elements of serums exudates, do not afford any more definite information.

Within the past three years tuberculin has again been strongly advocated in various quarters as being the best early test. The fear of this preparation which arose shortly after its introduction by Koch has now been to a great extent allayed by the re-

searches of many competent observers and the view is now generally held that tuberculin when carefully employed in proper doses and in a particular manner is free from harmful effects. The hypodermic use of tuberculin has been to a large extent displaced by the local use of this substance in various ways.

The conjunctival test of Calmette is now very generally discarded an account of the very severe reaction which occasionally follows its employment. The method now in vogue are the cutaneous test of Von Pirquet and the Moro or inunction method.

The cutaneous test of Von Pirquet has proved to be of extremely great value and is probably destined to replace all others, including the hypodermic mehod. In children a positive reaction is definite proof of tuberculosis. In adults a prompt and marked reaction is also presumptive evidence of recent and active disease. Mild delayed and sluggish reactions are of doubtful value. Negative reactions are extremely valuable and can be considered generally to exclude tuberculosis.

The Moro test in which tuberculin is simply rubbed into the skin has not been so much studied. It may prove to be a method of great value. It is free from danger and discomfort.

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THE TUBERCULOSIS EXHIBIT AT THE PROVINCIAL FAIR.

THE Tuberculosis Exhibit at the recent Provincial fair at Halifax attracted widespread attention and was highly creditable to the ladies and gentlemen concerned in its management. This move on the part of the recently organized anti-tuberculosis league will do more to educate the public in respect to the prevention and cure of tuberculosis than any other scheme proposed.

The exhibit itself was not a large one, but it was very tastefully arranged, and designed to bring out and iluustrate the essential problems in connection with consumption. A feature of the exhibit not to be overlooked was the short pithy addresses given by members of the committe in charge on the various aspects of the crusade against the great white plague.

EXCISION OF THE KNEE JOINT.

By CHARLES OGILVY, M. D.,

Adjunct Professor in Orthopedic Surgery, New York Post Graduate School, Attending Surgeon New York City Children Hospitals and Schools, Asst. Attending Orthopedic Surgeon N. Y. Post Graduate Hospital, etc., etc.

(Read before N. B. Medical Society, July 21st, 1909.)

EXCISION of the knee joint is indicated more frequently than is the rule in general practice. Our object in treating any lesion of the lower extremity, is, in every case, to procure as serviceable a walking limb as possible. There are many cases with knee joint involvement, which are walking about with considerable difficulty and not infrequently with much pain: cases which could be relieved of all pain and have a comfortable walking limb, by an excision of the joint.

The fear of entering a knee joint because of its being "particularly prone to infection," is hardly justifiable at this late date of aseptic and antiseptic surgery.

It is often a mistake to disfavour an excision of the knee joint because of the resulting ankylosis. A stiff knee is frequently much better than one with five or ten degrees of motion and is always preferable to a diseased joint with a few degrees of motion, when such motion causes a chronic condition of irritation and continues the disease indefinitely.

It is also wrong to consider that a stiff knee joint produces an unserviceable limb, for this is by no means the case. True, it is that a stiff leg is less easily controlled, but patients soon accustom themselves to this inconvenience and seldom complain.

The continued use of a knee brace when the function of the joint is lost, often gives more trouble and a less useful limb than if the joint be excised. Excision eliminates the necessity of wearing a brace and this is of material advantage.

This subject confines itself in great part to adults, and before considering the conditions in which excision is indicated just one word, condemning the excision of the knee joint in children, except in extreme cases. One only needs to see the results of such cases to be impressed with the great amount of shortening that takes place as the child grows to adolesence. This may be upwards of seven or more inches, depending upon the age of the child at the time of the operation. For example, a little girl of seven recently referred to the writer had had an excision of the right knee when she was two years. Now, five years later, there is a shortening of three and a half inches which will finally result in at least seven inches of shortening. The operation of choice in childhood is that of erasion, and this is to be repeated several times if necessary. The growth of the epiphysis is then not interfered with. Ollier has estimated that the growth of the femur takes place equally at its upper and lower epiphyseal lines until the fourth year of age, and that later, about three times greater at the lower extremity than the upper.* On the other hand it is much more desirable to have a short stiff limb rather than an artificial one, notwithstanding all that is said in favour of artificial limbs, for the best of them are none too good and certainly do not compare in utility with the natural limb, even though it be much shorter:

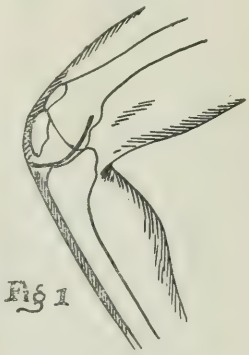
* Ollier Annals of Surgery, 1886.

so that in childhood, excise rather than amputate, but never excise when repeated erasion and free drainage will suffice. Thus excision in children is only indicated where disease is present and when that disease is so severe as to threaten the loss of either life or limb. Flail knee joints in children should never be excised, neither should we excise the joint for deformity whether or not ankylosis is present. For the flail joints, braces can be adjusted which will render the leg serviceable until full growth of the bone has taken place. For deformities — osteotomies, tenotomies and stretchings with the application of braces when necessary, should be the line of temporary treatment followed.

Indications.—In adolesence excision is especially indicated in those cases of long continued tubercular disease with recurrent exacerbations of acute symptoms. If after brace treatment has been employed and extension, immobilization and protection of the joint has been thoroughly carried out for upwards of two years, without checking the disease, and if as generally the case, the vitality of the patient is poor or, in other terms, his opsonic index is low, then an excision will eradicate the disease and immediately improve the general condition.

A very important personal factor is also to be considered and that is the wage-earning capacity of the patient, and the responsibility devolving upon him or her in this regard. An active tubercular process in the joint may incapacitate a patient for several years and this is a very serious consideration from the wage-earners' point of view.

One does not by any means advocate the indiscriminate excision of all tubercular joints in adults, for there is no tubercular joint that should not, in the earlier stages of the disease, be treated conservatively. By this is meant brace treatment with extension immobilization and protection as mentioned above. There are, however, cases which continue on year after year giving more or less pain and always a constant state of chronic inflammatory reaction. The function of the joint is already lost. Partial ankylosis is present. There are but a very few degrees of motion. Walking is painful and any sudden twist or jar is liable to set up an acute inflam-

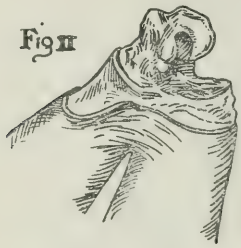


Line of cutaneous incision.

matory reaction. A walking brace with fixed joint or one allowing a few degrees of motion is usually employed with little relief and no cure. Such cases are promptly relieved by excision, the general condition is greatly improved and our patient is enabled to return to his accustomed vocation in three months from the time of the operation.

Class 2.—Excision is also indicated in cases of ankylosis with deformity. One deformity frequently seen is that of marked flexion, with or without a

subluxation of the head of the tibia backwards on the femur. Ambulation is difficult and fatiguing, owing not only to the deformity, but to the shortening of the distance between the hip joint and the foot by reason of the flexion. When such a leg is used for any length of time, second-



Joint hyperflexed ready for saw cuts.

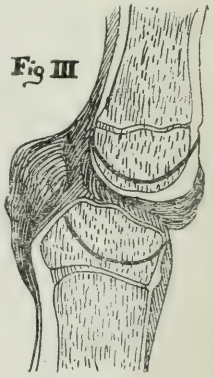
ary deformities result in the spine and pelvis, in the effort of the body to maintain the upright position. We also see cases of genu recurvatum with ankylosis which demand excision and a correction of the backward curve, for this deformity if untreated will gradually increase from the strain of carrying the body weight. One case of lateral displacement with partial ankylosis has been treated by the writer. This was a case of severe traumatism resulting in a slight lateral displacement, which was not recognized, as such, at the time the injury was first treated.

A third class of cases in which excision is indicated is that of flail joints which cannot be successfully controlled by bracing.

Other conditions present themselves which cannot be classed in any one of the three above groups, but which must also be treated by excision in order to obtain the best results, such as selected cases of osteo-arthritis and occasionally acute destructive- pyogenic infections.

Operation.—The operation to be described is one which was originally devised by Fenwick. Little mention is made of it in the text books and for this reason and because of its efficiency and advantages over other methods of operation I present it for your consideration to-day.

Two esentials in the operation are a good exposure of the structures involved and a technic which enables the operator to work quickly. To open the knee by cutting through the patella for an excision of the joint means loss of time. More time is lost in uniting the fragments, if the patella is to be retained. If, as is generally advisable, the patella and its adjacent structures are to be removed much time is saved in resecting them "en masse." The difficulty of exactly approximating the cut services in the

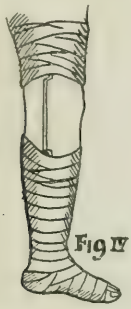


Showing line of saw cuts.

desired angle of one hundred and seventy-five degrees frequently necessitates several saw cuts when a straight cut is employed. With a curved surface on both bones, this

is not the case: on the other hand the leg can be put up at any angle desired, with perfect apposition of the cut bone surfaces always assured. The bones are firmly retained in position without the use of nails or wire. Seldom is it necessary to ligate a single vessel.

TECHNIC.—After elevating the limb for a few moments an Esmark bandage is applied high up in the thigh. An anterior curved incision (fig. 1) is made with its convexity downwards, starting from immediately above and



Plaster of Paris Dressing with steel bar bridging over joint.

slightly posterior to the inner condyle of the femur, sweeping across the patellor tendon mid-way between its patellar and tibial attachment, and up the outer side to a corresponding point above the external condyle. This incision is made with one sweep of the knife, and includes the skin and subcutaneous tissues. This flap is resected upwards exposing the patella with its adjacent structures. An incision is then made around the patella including all the structures on the anterior surface of the joint which are thus removed, the dissection extending back to the lateral ligaments on either side. After thus opening the joint the lateral ligaments are partly divided, the undivided portion being separated subperiosteally, to allow of forced flexion. The synovial membrane is resected. The crucial ligaments are divided. The articular ends of the femur and tibia are then freed of all their attachments. The assistant now forcibly flexes the joint (fig. 2), thus projecting the articular surfaces of the bones and giving a good exposure for the saw cuts. With this forced flexion the popliteal vessels are crowded backward behind the posterior ligament, being thus protected from injury. Should any resection or curretting of the posterior ligament be necessary, care must be taken not to injure the popliteal artery which lies immediately behind it. With mouse toothed forceps and curved scissors all the remaining diseased tissues are quickly trimmed away. A bow saw is used for the incision. The saw is applied parallel to the curved surface of the articular end of the femur (fig. 3). It is entered anteriorily just above the articular surface. The depth of this saw cut determining the amount of bone to be removed is in each case a law unto itself and will usually vary from one quarter to five-eights of an inch. A concavity, with a curve corresponding to this convexity, is then sawn out from the upper end of the tibia, in which the newly cut surface of the femur firmly fits. This is also made from before backwards.

If the case is one of tuberculosis the ends of the bone and immediately surrounding structures are swabbed over with pure carbolic acid, care being taken not to allow the acid to flow to the edge of the wound over the skin. This should remain on for one minute and a half after which alcohol should be thoroughly applied. The

whole field of operation is then irrigated with a solution of one to two thousand bichloride. The leg is now extended and the ends of the bones fitted firmly together. Five to six interrupted chromicised cat-gut sutures (No. 1) are used for uniting the deeper structures. The skin is sewed with a continuous plain cat-gut suture (No. 1). If there is reason to expect a continuance of the active processes of disease, two cat-gut drains are inserted into the joint, one at either end of the incision. A liberal shaken out gauze dressing is tightly bandaged around the knee.

The Esmark is now removed. The limb is then elevated to a right angle while the dressing is completed. This insures the closer apposition of the cut, femoral and tibial surfaces. Smooth sheet wadding is applied from the groin to the toes and with the knee flexed at one hundred and seventy-five degrees of flexion, a plaster of Paris cast is applied from the groin to and including, the foot. Two steel rods are inserted one on either side arching over the joint (fig. 4), the ends of which are incorporated in the plaster. This enables one to dress the wound without disturbing the fixation.

Unless there is some special indication this dressing is undisturbed for three weeks. At the end of six weeks the plaster of Paris cast is removed and another one applied. Three or four weeks later the anterior part of this is cut away leaving a posterior moulded splint which should be worn for upwards of five months.

The advantages of this operation are:

(1) The perfect exposure of the operative field.

(2) The rapidity with which it can be performed.

(3) The completeness of removal of all diseased structures.

(4) The assured apposition of the cut bone surfaces.

(5) The ease with which the knee can be placed at the desired angle, and retained in this position.

THE USE AND ABUSE OF THE PROVINCIAL SANATORIUM.

Editors of the
MARITIME MEDICAL NEWS:

DEAR SIRS,—I have only recently read a paper in the July number of the MARITIME MEDICAL NEWS by Doctor D. A. Campbell, touching on the work of the Provincial Sanatorium, a communication that would seem, in all fairness, to require some amplification by one who has had a more or less guiding hand in Sanatorium affairs since its opening in 1904.

After reading this paper by Doctor Campbell no one can doubt the conotention which I have been making in season and out of season for the past five years. That, generally speaking, the medical examiners appointed by the Government of Nova Scotia have made a mis-use of this institution in sending here far advanced and incurable cases of consumption—a fact now notorious throughout the Province.

I propose to show, that had it not been for the proper, prompt and extraordinary efforts of the persons entrusted with the management, the entire purpose and object of the Sanatorium, would have been defeated, as it is, it has been almost defeated.

Doctor Campbell presents us with a summary made up of Doctor Woodworth's classification for the first four years. We find that of the first two hundred and forty-five admissions, seventy-three were incipient and one hundred and seventy-two were advanced, of the latter ninety-three being moderately advanced and seventy-nine far advanced.

I am told by Doctor Woodworth that he strained a point in this classification to call seventy-three incipient, that many more should really have been classed advanced. Of my own personal observation of these patients I may say that in these advanced cases were found almost every complication and symptom known to exist in the latter stages of consumption.

It must be remembered that the scope and purpose of the work here were well known. It was built as a model Sanatorium, where persons of both sexes and different ages could live, under proper supervision, an ideal life, from the hygienic standpoint. It was not a large institution with different wards and various departments as at Rutland, or with many cottages as at Muskoka. There was but one living room and fireside for all to gather about, one dining-room for all to assemble in, piazzas and writing rooms common to all. What affected one affected the whole household.

It was very well known that there was no resident doctor here, yet many of these one hundred and seventy-two advanced cases were so seriously ill as to require almost constant medical advice. They were liable to severe hæmorhages, subject to great variation in temperature, and in short had in varying degrees the distressing symptoms which accompany advanced disease in any form.

When I took charge here five years ago I was told to prepare for the reception and care of eighteen incipient cases of tuberculosis, with a physician, whose standing is second to none in Nova Scotia, near at hand to visit patients and take charge of their medical treatment. This did not seem to be an unreasonable or alarming proposition. If I had known or could

have foreseen the burden that was to be placed on my shoulders, I would have hesitated long before assuming so grave a responsibility.

It can be said in all truth, that there has hardly been a month go by in five years that I have not been trying to arrange to get incurable cases returned to their homes , with the least possible distress to the patient, acting of course in this matter on the advice of the attending physician. In nine cases the difficulties were insurmountable and the patients died here. Three of these cases were patients who came here with ear and throat complication and rapidly developed tubercular meningitis. It was of course impossible to remove them after the cerebral symptoms set in and each one lingered for from eighteen to twenty days in the semi-unconscious state usual in these cases.

I have been implored, entreated and persuaded by friends to keep patients here who should never have been sent. In some instances, almost threatened that I would be compelled to keep certain cases.

A young man went on his knees and begged me to keep his wife a little longer although the doctor had pronounced her case incurable. In less than a week she had died of hæmorrhage.

A young lad once said to me, " You shouldn't have been so kind to me Miss Elliot, if you were going to send me away." But I knew his mother would reproach us if we did not get him home before it was too late. The medical examiners had not the courage to steel their hearts, but it was absolutely necessary for me to steel mine.

The second patient admitted here in 1904 was a far advanced case who died in five weeks. She belonged to the Salvation Army and I could make no arrangements to get her home.

The three hundred and second case admitted here was far advanced. Between this second and this three hundred and second were other eighty-five or ninety of a similar character.

A young girl came here from Halifax at one time and on examination, the entire area of both lungs was found to be involved and softening. She was returned in a few days. It required both parents to get her here and back. They were poor people and this worse than useless journey cost them about twenty dollars. Their pockets and bags were loaded with rags she had used to expectorate in on the journey.

A young man came into Sanatorium one evening from one of the eastern counties. He had the look of death on his face when he came in the house. He was put to bed and the doctor summoned. Nothing could be done for him and he died in a week. He was a poor man with a little family at home. He had sold some of his stock to buy an outfit and pay his expenses here. The journey here had taken him twelve hours and he had been expecorating freely. I asked him how he managed with it and he told me he had used rags and thrown them out of the window.

A little over a year ago a patient came here who had every symptom known to medical science of far advanced phthisis. She was emaciated, known to be subject to hæmorrhages, high temperature, etc., the attending physician advised me to get her back. Owing to some domestic changes in her home there was some delay in this. The evening before she was to go away I was suddenly called to her as she had began to spit blood. She was still in her rocking chair and as I

tried to get her on her bed she coughed up an immense quantity of blood and expired at once. Several young girls who were preparing for tea in the same piazza were witnesses of this frightful sight. This patient had told me herself she had had consumption about five years and knew she was in the last stages.

A few months later the doctor who sent this woman called me up on the telephone and said he had one or two early cases to send me if I did not have the house filled with "those advanced cases!" It must not be understood that these instances presented here at some length were exceptional —scores of others equally as bad might be given—at least in the neighbourhood of four score. It can readily be imagined what an enormous amount of mischief these cases would do in the community from which they came in creating prejudice against the Sanatorium. There was no one to give a public explanation and say there was no other result possible in these cases.

Yet during these years good work has been done for the more suitable cases. As Doctor Campbell points out in his paper sixty per cent. have been sent away apparently cured, results which compare favorably with those presented by other Sanatoria.

We are constantly in receipt of letters from ex-patients, who give bright accounts of how they live now, compared with their manner of life before coming to the Sanatorium. Sleeping rooms are kept always opened and old carpets and hooked mats and hangings flung out. Windows taken off bodily. Piazzas, porches and log cabins are built where such things were not thought of before. This has been going on for four or five years and we really have been pioneers in the anti-tuberculosis line although so scattered in different parts of the province as hardly to be noticed.

When the Provincial Sanatorium was opened five years ago it was a comparatively new work and to a certain extent experimental, yet the lack of interest taken in it by the medical profession in general has been amazing. Although it was built by the Government at the earnest solicitation of the medical profession, the attitude of the latter has been cold and indifferent, one might say in some respects, almost hostile. Can any one in the ordinary walks of life find this statement credible? yet it can be sustained. There are medical gentlemen in this community who have never shown the slightest professional interest in any way, shape or manner in this Sanatorium, although I came here a stranger to engage in a work analagous to their own, that of relieving suffering humanity. Strangers, medical gentlemen and others have come here from other parts of the world thoroughly acquainted with Sanatorium principles. They have expressed unqualified admiration and approval of all the arrangements and given pleasant words of encouragement and sympathy. But in our own province we hear of doctors who have never entered the premises, speaking of the Sanatorium in terms of indifference and disapproval or even pride themselves on knowing nothing whatever about it. There are several names on the list of medical examiners who have never been near the institution.

Three years ago a patient was sent here about as desperately advanced and incurable a case as we ever had, who told the following story to Doctor Woodworth and myself on taking his history. It was told with such directness and simplicity and such an

entire absence of malice that one could not doubt it. Fourteen or fifteen months previously he had had an attack of what seemed to have been pleuro pneumonia. Upon recovery from that he had gradually gone down. He lived in a boarding house—it was a seaport town—and went to a doctor's office once or twice a week. He frequently had his prescription changed. After this had gone on for over a year and his money was about gone he went some miles away to his father's house. In this neighbourhood he met an ex-Sanatorium patient who filled him with an earnest desire to get here at once. He went back to the doctor who had been treating him and asked his advice. "I know nothing at all about that place'," he said, and dismissed the subject. It was in 1906, two years after the Sanatorium was opened. The patient went to another doctor who took steps to find out at once if he could get here. There was a vacancy. He got his papers and he came. He was emaciated and hectic. I said to Doctor Woodworth, "Doctor, is the word for this manslaughter?" He replied, "Manslaughter is the word." We kept the poor fellow for some weeks out of humanity, but he had to go home to die. He said before he went, "Miss Elliot, if I could have come here a year ago I might have got well, but I knew nothing about it."

Different persons who have visited the Sanatorium have said to me many times, "Why don't you put a stop to the examiners sending these terrible cases here?" I am now on record as having done everything in my power to stop it. Bringing it continually to the attention of the Government and the Government Inspector, even personally expostulating with the medical examiners. One examiner to whom I wrote suggesting in the interest of suffering humanity that he advise far advanced cases to remain at home, sent me a most discourteous reply.

This Sanatorium was built under an Act of the Legislature for the reception and care of incipient pulmonary tubercular cases. This Act has been outrageously defied. I would like to know in the name of all that is good and wise and sensible, what end is served in carting dying phthisis patients from one end of the province to the other. Is the Sanatorium served? Is the suffering patient aided or the patient's friends or the general public benefitted? No! it is an injury and betrayal of all. Can any one imagine for a moment what harm may be done by old established cases of consumption—loose perhaps for a year or more—travelling about in public conveyances, possibly with little care at home of expectoration and very probably with every article of clothing infected with bacilli—old black skirts, woollen shawls, cloth skirts, etc. Such cases have been known many times to have stopped at some hotel over night on the way here. Is this the way to stamp out tuberculosis? No one will find it hard to believe that the reception here of patients so widely different in condition of disease has placed enormous difficulties on the management. Not only do we get persons of every station in life and both sexes which was to be expected, but we have had placed here in one little household every known stage of tuberculosis. Early cases full of life and nonsense, wanting entertainment and something doing. Advanced cases, complaining, fault finding, querulous. Far advanced cases, suffering, moaning, dying, requiring extra nurses, friends and relatives sent for, etc.

The medical profession would be interested I am sure in our weight

charts, which compare favourably with those of other Sanatoria. Most of the early cases and many of the more advanced show marked gains in weight. Ten, twelve, fifteen and eighteen pounds in three months are common. Twenty, twenty-five, twenty-eight in four months and so on. All of which speaks well for the nutritive quality of the food provided, although there has been difficulty in this department also which need not be dwelt upon here.

It is a pleasure to be able to say that the past year has seen some improvement in the condition of cases coming here, although several within that period have been entirely unsuitable. Only two months ago we admitted a little boy with hip joint disease and who had right lung softening. His nutrition was at lowest ebb, his stomach weak. He was twelve years old and weighed thirty-nine pounds. His temperature ranged from ninety-six to one hundred and two. He was treated here with greatest tenderness, but he never should have been sent. It was my task to grieve and disappoint him by telling him I had sent for his father to take him home. But generally speaking the cases of late have been earlier.

We are also reaping the benefit of the good report of cases who have done well during these years and who have spread encouraging stories in different sections of the province. For I may say, that in spite of all difficulties, we have so handled the more suitable cases that the place is becoming more and more favourably known in our province and we are constantly in receipt of letters of gratitude and good wishes.

For the past four months the Sanatorium has been more than ever taxed to its full capacity with comparatively few bed patients. I am able to point with pride to a smoothly running Sanatorium, which was the aim and end in view in its construction. It remains for the medical profession to acknowledge in a spirit of justice that this end has been achieved in the face of tremendous difficulties, carrying what Doctor Campbell so justly calls "the sins of others."

It may be said that advanced cases find their way in all Sanatoria and often do well.

The management has never made any great objection to the admission of the moderately advanced although this was not intended in the first instance, but for the medical profession to force in here so many terminal cases and then talk of disappointing results and lack of confidence in the management is a travesty on fair play.

A French lady came here about a year ago who was sent by Doctor Richer of Montreal, purposely to inspect this Sanatorium. She had been to many Sanatoria in France, England, Germany, Denmark and the United States. I asked her for suggestions. She said she had none, it was as near perfection as anything she had ever seen in this line. She said it was good enough for a prince and yet not too fine for the simple and humble.

The aim here has been to make this Sanatorium not only a model from a hygienic point of view, a place of beauty, order, comfort, dignity and refinement, but a home which should be a living exemplification of the practicability of the method of living. It will be seen that the Sanatorium idea as presented here may be adapted to every day life. A few years ago a housekeeper would have been horrified to be told that she must make an

attractive home with unpapered walls, bare floors, no hangings or stuffed furniture of any kind.

A lady who spent a few months here as a patient said to me, "There is no reason why this method of life could not be adapted to every home in Nova Scotia, either rich or poor, I am going home to throw out nearly everything in the house and begin over again."

I beg to say to the medical profession of Nova Scotia that I have done my part here and have given it of my best, the result of many years of experience. I am asking them if, in reference to the work here, they think they have done their part.

Dr. Campbell remarks that it is generally felt that something should be done to place the work here on a higher level. Will that high level, so much to be desired, ever be reached while the medical examiners continue the course they have followed during the past five years? When medical gentlemen of the highest standing after examining a patient and finding involment and softening of a whole lung, with a history of eighteen months cough, dyspnœa, free expectoration, loss of weight and strength, will take the certificate and place his signature after words which read, "I have personally examined ————, and certify that he is suffering from tubercular disease of the lungs in its first or incipient stage."

Sincerely yours,

BERTHA ELLIOT.

Provincial Sanatorium,
Nova Scotia, Sept. 30, 1909.

ACUTE RHEUMATISM IN INFANCY.

Case Report.

By JOHN JARDINE, M. D.,
Summerside, P. E. I.

(Read before the Maritime Medical Association.)

MR. President and Gentlemen.—The comparative rarity of the condition, if my diagnosis be correct, is my apology for presenting a report of a case of Acute Rheumatism in Infancy.

The difficulty of deciding upon a positive diagnosis in this case has likewise had its influence in the same direction.

The subject of our report is an infant of nine months. Patient was a well nourished child. Birth had been natural, no instruments having been used in delivery. Although a bottle-fed child, did well. She was fed according to Dr. Holt's formula. The mother being of more than average intelligence the child was hygienically cared for. The diet was increased so that a maximum of food ingredients were admisistered consistent with the child's digestive powers. Child had never been fed on proprietary foods, condensed or sterilized milk.

At three months child had slight diarrhœa lasting about 36 hours, from which she made a rapid recovery. Otherwise had always been healthy. Child was bright and presented a healthy appearance. Was of good average size and weight. Child seldom cried. In fact, she was as we say, a good baby.

Family History.—Parents never had Acute Rheumatism. Both, however, are subject to sevère neuralgia, particularly the mother who might be almost considered a martyr to this trouble. Maternal grandfather is also markedly subject to the same affliction.

The first symptom noticed in this sickness was pain on motion, active or passive, of the left ankle joint. Examination of the child revealed no redness or swelling of this joint, but on the slightest movement the hitherto good baby would cry out evidently because of pain. Reflexes were normal. There was no wasting of the muscles. Temperature, 98 1-5. Pulse rate not increased. Think the trouble was the result of some slight injury, the joint was treated as such, but only to find a similar trouble developing in the left knee joint in about one week. Then the left hip became involved. Very soon the joints of the opposite limb became affected. We must confess we were greatly puzzled as to the condition. Attention was paid to the child's diet. No error in this could be detected. In our dilemma the hands and arms became involved. Child would not move its hands and the slightest movement caused great pain. All these joints became affected in about three weeks.

By this time the child developed a slight temperature—100 2-5. Pulse rate was slightly increased. There was no cardiac murmur. Our patient was now losing weight, digestion became impaired, appetite was failing. It looked as though the case was going from bad to worse. Although the elevation of temperature was slight and had been so long delayed we resolved to treat the case as one of

Acute Rheumatism. Aspirin was prescribed. To this the patient responded. No change was made in the diet. Temperature dropped to normal, and the pain was gradually disappearing.

After the child had been so treated for about one week we resolved to withdraw the drug, but only to find a return of the pain. Began again to improve on resuming the administration of the drug. The treatment was continued for some weeks, the drug being gradually withdrawn. Iron in suitable doses was then administered.

Thus from an apparently hopeless condition in which the child would cry out on the slightest movement of any joint and in which the general health was fast being impaired, we had the happy termination of a child completely restored to health.

At the outset we stated that there is a difficulty in diagnosing our case. We still think there is some doubt whether the condition should be called Infantile Scurvy or Acute Rheumatism.

Regarding Infantile Scurvy, we read that it—

1. Is commonly met with in children under one year.

2. Is usually the result of improper dietary, yet it may be present even in breast-fed infants.

3. May be of a mild type in which no other symptom is present except marked tenderness of the limbs.

4. May have slight yet often no increase in temperature.

5. Has no cardiac lesions.

6. Treatment consists of suitable diet, with beef juice, fruit juices and vegetable salts of potash.

Acute Rheumatism, on the other hand in the child, manifests itself in other ways than in the adult.

Articular complications are less severe.

Temperature is less elevated.

Is largely hereditary.

Is a rare disease in infants under one year.

Applying these facts to our case, we must admit that there is much to simulate the former condition. Yet here we have recovery without any change in diet—as a matter of fact the diet both before, during, and after the trouble was always carefully prepared so that it contained a maximum of food ingredients consistent with the patient's digestive power.

Secondly, we have the patient's response to the Salicylate treatment. The pains again appeared on the withdrawal of this drug, to be again relieved on resuming its administration.

Thus, we are inclined to diagnose the condition as Acute Rhematism, although such eminent authorities as Drs. Poynton and Hutchinson, in Osler's Modern Medicine, and Dr. Holt of New York, strongly advise caution in making this diagnosis in infants under one year of age.

CASE REPORTS.

By VICTOR F. CONNOR, L. R. C. P. and S. I.,
Great Village, Col. Co., N. S.

Case I.

Suture in Radical Cure of Hernia.

(Read at meeting of the Maritime Medical Association.)

IN doing a radical cure for hernia, I lately thought that I would suture the rings in a way to avoid having several sharp points of wire. I therefore passed the needle containing the silver wire through the inner pillar of the internal ring, then, in front of the cord, through the outer pillar, twisting the wire tight enough to bring the pillars firmly together. Then, without cutting the wire, did the same thing halfway between the rings, twisting tight again, and then through the outer ring pillar behind the cord, and twisted thus only having one pair of points, which were laid closely along the wire, instead of three.

Case II.

Note on a Case of Basal Fracture of the Skull.

MR. G. C., age 56, coming out of a lighted room into a dark passage, did not see the stairway, and fell sideways down about 12 feet, stopping head foremost against a sharp-edged door-post at the foot of the stairs.

Judging by his injuries, he must have landed halfway down on his face, cannoned against the bannisters, slid down the remaining stairs and across the hardwood floor, landing for about four feet before striking the door-post.

He lay for about five minutes before being picked up, losing a lot of blood.

I arrived on the scene about three minutes later and found the patient on a couch with his head being bathed with hot water. On examination, a C shaped wound was seen on the right fronto temporal region, about 5½ inches in length, the inner portion of the scalp being detached and bleeding profusely.

There was a ziz-zag wound on the nose 1½ inches long and ½ to ¾ inch deep, the nasal bones also broken. The upper lip was cut through, one tooth knocked out of the upper jaw and the teeth on either side of it loosened and the inner surface of the lower lip also split.

The skin on the right side of the face and neck was much abraded. Bleeding was going on from the wounds, mouth and nose. I sutured up the scalp wound, catching the artery in one of the sutures, also the nose wound and lip.

Bandaged the head with compresses on wound but oozing still took place from the scalp, so in about two hours I redressed this, dusting tannic acid and increasing the pressure.

Also plugged the nostrils to fix nasal bones. Got the patient to bed,

after further examination for crepitus, but without finding any.

When the head was laid on the pillow, there was immediately seen an increasing wet patch on the pillow-slip, and on raising the head at once, a clear, pale straw-colored fluid ran from the ear, also more was coughed and spat from the mouth, running from the posterior nares, mixed with clots. I at once plugged the anterior nares, and placed the patient with this ear upwards, which I plugged lightly, and then looked forward to the speedy demise of the patient, my fears of fracture of the base being thus confirmed. The pulse was rapid but regular and as would be expected from the loss of so much blood.

However, by administering an opiate to calm the excitement as the patient had been partaking of some whiskey previous to the accident, rest and absolute quiet in bed, the patient did well. Further treatment consisted in removing the plugs, syringing, with hazeline and carbolic solution, of the nasal cavities, replugging twice, after the second day, although more fluid came from the nose, none came from the ear, recovery was uninterrupted.

No elevation of temperature took place, 98° to 98.4° being the range, and eleven days later I took advantage of the snow storm to take the patient home in a covered sleigh, a 26 mile drive.

He drove up here lately, some four months (April) after the accident, looking and feeling fit.

My diagnosis was fracture of the base through ethmoid and sphenoid.

Charlottetown, P. E. I.,
8th October, 1909.

Editor MARITIME MEDICAL NEWS:

DEAR DOCTOR,—I received your magazine for September this morning wherein you give me credit for reading a paper on "My Experiences with Antitoxine Serums," at the meeting held last July. Please correct it and give the credit to Dr. Alex. Macneil, of Summerside, P. E. I. I can't understand how you came to couple my name with it as I read no paper at said meeting—was not present at the meeting.

Yours truly,
R. MACNEIL, M. D.

[The paper published in the September issue of the NEWS, "My Experience with Antitoxine Serums," and credited to Dr. R. MacNeill, of Charlottetown, was written by Dr. Alexander MacNeill, of Summerside, P. E. I. We regret the error and trust that this explanation will be regarded as satisfactory.—Editor MARITIME MEDICAL NEWS.]

SOME FEATURES OF THE ANTI-TUBERCULOSIS MOVEMENT IN BOSTON.

By MRS. A. I. MADER,
Halifax, N. S.

(Read before Council of the Halifax County Anti-Tuberculosis League.)

HAVING experienced some difficulties in my particular work in connection with the Anti-Tuberculosis League, I felt that by visiting some centre where the work has been going on for some time and is well organized, I should surely receive help. Accordingly I went to the nearest centre, Boston.

The initial work of the Halifax County League, compares well with that of other cities; but I think the time has come when we must go forward. Before I make any suggestions, however, I may quickly go over the tuberculosis activities which I visited in Boston. The Boston Association for the relief and control of Tuberculosis, 4 Joy Street, has been in existence for some six years. They began much in the same way as we did, and carried on the work for four years, until they succeeded in convincing the city of Boston that it was their business to care for the tuberculous poor. Since then the Association has existed to carry on what they term purely educational work.

Mr, A. Wilson is the general secretary of the Asociation. He has been in the work for a number of years, and it was largely through his untiring efforts that the Day Camp at Mattapan for ambulatory cases was established. They also established the school for Tuberculous children at Francklyn Park, and a dispensary.

Two years ago the city council of Boston were convinced that this was their work and they appropriated a large sum of money for this purpose. The camp at Mattapan was taken over by the city, and early this spring they added a building to the plant already there, which accommodates twenty-four men day and night These cases are too far advanced for Rutland, but hopeful. The day camp cares for about 250 cases yearly. These people get three meals at the camp, and have their home conditions looked after by the visiting nurses in the city.

At 13 Burroughs Place is situated the dispensary. This place is known as the Boston Consumptives Home out-department, but it has been aptly termed by one of the physicians the "clearing-house" for all their work. To this place all patients come to be examined. Patients are sent from this place either to Rutland State Sanatorium, or if far advanced and, without homes, to some hospital where they care for these cases, and if in poverty the city pay for their care at these hospitals, $8.00 a week. Ambulatory cases are sent to the day camp. If they are to be cared for in their own homes, and by far the largest number are thus cared for, they are visited by the nurse and cared for in this way. When the hospital for advanced cases, which is situated on the grounds at Mattapan near the day camp and cottage hospital for men is completed, there will not be the same need to hire beds in other hospitals for the advanced cases. This hospital has one wing completed, and it was an interesting experience to go through this building. The construction cost of the hospital is to be

$1.500 a bed. It has been carefully planned (the planning has taken the city two years), and the heating, lighting, and ventilation have been matters of paramount importance. In connection with the dispensary there is a staff of three or four doctors, with assistants, a nose and throat specialist (every case has this examination) and twenty-five visiting nurses. Two years ago they had eight nurses. There is a pathological laboratory also in this building, but this equipment is however, meager. Here are kept all the records and histories taken by both doctors and nurses, and here the home cases come to report as often as the doctor considers necessary. There are patients discharged to their own physician with a diagnosis from the doctor in charge of the clinic. Through the dispensary the cases are discovered, and a fight with the enemy located is, compared with the enemy in ambush, simple. The work of the visiting nurses is helped very much and the problem simplified by a weekly conference of the nurses with the social workers, and the associated charities. This conference is held in the different districts and in this way all the charities co-operate. In the matter of supply the city through its organization dispenses 600 quarts of milk daily, also eggs. It loans cots, tents, etc., and builds balconies and shelters. The dispensary is also supplied with linen, sheets, pillow slips, ice bags, etc., etc., by kindly disposed people who desire to help in this way. These things are loaned to the patients through the nurse.

To sum up, there is (1) the "clearing-house" at Burroughs Place, at which place all patients are received, and from which place all patients are discharged.

(2) One hundred beds are obtained in hospitals, for the advanced or terminal cases, and the city pays $8.00 per week for these beds.

(3) The home treatment is carried on by a staff of visiting nurses, 25 in number.

(4) The day camp at Mattapan.

(5) The school at Francklyn Park for tuberculous children (not entirely under city control).

(6) Rutland State Sanatorium.

(7) Various classes.

(8) Private physicians.

This plan of organization is not original with Boston, but has been somewhat elaborated from the organization plan of Edinburgh.

Our problem, of course, is much smaller than the problem of Boston, but there is no reason why that which "the Association" has demonstrated to the city of Boston need be done all over again in Halifax. Because half the cities in the civilized world are caring for their tuberculous poor is reason enough that this city should do likewise. It is, of course, the business of our League to create public opinion. This done, our City and Provincial Governments, yes, and our Dominion Government together with all our existing charities and philanthropic organizations will do the rest. We as a league will then exist for the dissemination of knowledge, by lectures, the exhibit, etc., etc. I would suggest then that in the first place, we need a central office which shall be open all day. Here all our records shall be kept, our literature sent out and where all interested in the work shall feel free to come and find out just what the League is doing. Possibly we might have a small part of our exhibit constantly on view in this place if it were large enough. All doctors

would have access to our records, and this I think would do much to popularize our work with the medical profession.

In the city of Halifax the doctors will provide the patients for our League to work for, as we have no hospital with an out-patient department, and all people in Halifax have their family physicians except the destitute, who are cared for at the Halifax dispensary. In this central office there might be an examining room where any doctor having patients in charge of the League nurse, might meet his patients weekly with the nurse in attendance. It might be well for the League to have one or two examining physicians by whom poor patients could be admitted to the benefits of our work and also it would be wise that other patients whom we aid financially to any extent, might have an examination, if desired, by another physician or expert beside the patient's own physician.

I would suggest that Dr. Birt, who in the beginning of our work expressed his willingness to help when the time came for this kind of service, should be appointed.

I would suggest that all medical men in active practise should be invited to attend the meeting of the council. A big effort must be made to secure compulsory notification. Too much stress cannot be laid upon the necessity of having the charities of our city co-ordinated.

SYMPTOMS AND DIAGNOSIS OF GALL STONES.

By W. A. FERGUSON, M. D.,
Moncton, N. B.

(Read at meeting of the Maritime Medical Association.)

THE symptoms of Gall Stone disease are: pain and colic, nausea and vomiting, tenderness over gall bladder area, fever, tumour and jaundice.

Unfortunately, we rarely, if ever, see a case of gall stones in which this array of signs and symptoms is present.

The diagnosis is usually made from the presence of two or three symptoms only—pain in the upper abdominal region is the most common and important symptom. At times we meet with a case in which pain alone is the dominant symptom. It is sudden of onset and is referred to the epigastric or right hypochondriac region, extending to the back in the region of right shoulder blade. It is of a bursting and tearing character and accompanied by nausea and vomiting. In the greater number of cases the pain is less severe than this, and is usually referred, especially in the early stages of the disease, to the epigastrium, radiating at times to the right, and sometimes the left subscapular area.

Nausea and vomiting are the most important manifestations, and it has been stated, with much truth, that the most common symptom of gall bladder disease is indigestion.

Graham, the Internist at the Mayo clinic, terms the following group, gall stone dyspepsia. There is pain, usually epigastric, extending to right shoulder blade, flatulence, nausea, vomiting of yellowish, bitter fluid, mixed with mucus—the vomiting may be due to stomach irritation, but it is in most cases of reflex origin.

In one of my first cases, I saw the patient three weeks after the onset of pain and vomiting, and ten days after the complete withdrawal of stomach feeding, the patient being nourished by the bowel. There was vomiting every few hours of yellowish fluid. The patient looked very ill—there was some fever, with a poor pulse of 130.

At operation four large stones were removed, and within twelve hours the patient was taking liquids with complete absence of nausea and vomiting. Unfortunately pneumonia of right base developed on seventh day, and patient succumbed twenty-four hours later.

Tenderness of the gall bladder is best detected by sitting on the right side of the patient and placing the right hand over the lower right costal arch, so that the thumb may be pressed beneath the arch toward the under surface of the liver.

Murphy says: "The most characteristic sign of gall bladder hypersensitiveness is the inability of the patient to take a full inspiration when the physician's fingers are hooked up beneath the right costal arch."

During an attack of gall stone colic the temperature may rise abruptly. It usually subsides quickly between the attacks. Where secondary infection of gall bladder (acute suppurative cholecystitis) or of the duct (acute cholangitis) occurs, the fever assumes a septic type.

Tumour distention of the gall bladder occurs when the cystic duct becomes obstructed—a stone may be impacted in the pelvis of the gall bladder, or in the cystic duct. The

distended organ is often recognized on palpation as a smooth, pear-shaped swelling.

As illustrating the enormous distention that sometimes occurs, the following case may be mentioned. The patient, a middle aged woman, was referred for treatment of abdominal symptoms. There was an indefinite history of slow growing tumour, without much pain, until twelve days before coming to hospital. There was a slight evening temperature, no tenderness present. The size of the tumour suggested the possibility of it being an ovarian cyst. Operation revealed a huge gall bladder with thickened walls containing a large amount of pus and a solitary stone. The finger could be passed into the cystic duct and also into the duodenum, which was so intimately adherent to the gall bladder that it was decided to drain the gall bladder in preference to doing a cholecystectomy.

Jaundice is a rare symptom of gall stone disease. It is unfortunate too, as it has been the great stumbling block in the way of an early diagnosis. Without the presence of this symptom many medical men refuse to admit the presence of gall stones.

So long as the calculi remain in the gall bladder there is no jaundice.

The incidence of jaundice is due (1) to an extension of the infection down the cystic to the common and hepatic duct junction, the swelling of the mucus membrane producing obstruction to the drainage of bile from the liver; or (2) to the passage of a stone to the common duct where it lodges and produces obstruction. Jaundice, if present, is a symptom of the end results of gall stones.

The early symptoms ascribed to gall stones are but the symptoms of the inflammation which their presence has evoked.

The cholecystitis always precedes the formation of the stones. Operation based on these early symptoms—pain, nausea, vomiting and tenderness over the liver, may disclose a cholecystitis, but no gall stones.

The cholecystitis so found may be the precursor of gall stone formation, or the result thereof. The gall stones at one time present having in the latter instance escaped through the ducts.

The diseases that may be mistaken for gall stones are ulcer and cancer of the stomach and duodenum, appendicitis and right kidney stone. In most cases, usually appendicitis and kidney stone will be eliminated by a careful study of the case, and the diagnosis will be between gall stones and a lesion (benign or malignant) of the stomach or duodenum. There is one combination of symptoms that the great majority of cases fall under. There is sudden, severe pain in the stomach region or possibly over the gall bladder, with or without radiation to the back or right shoulder. This pain is always of short duration and may abruptly disappear even when at its height. If added to the above, we find sensitiveness of the gall bladder area, we can make a diagnosis with little chance of error.

The greatest difficulty at the time is to differentiate between gall bladder disease and ulcer of the stomach and especially Duodenum. In all three, at times the symptoms run very nearly the same—pain and distress, gas, belching, eructations, vomiting sour stomach.

In gall stones, the pain is characterized by sudden onset and disappearance, with almost immediate re-

turn to normal health. The vomiting does not give such relief as follows in cases of ulcer.

In ulcer the pain runs in decided periods lasting from a few days to several months—it is burning and gnawing in character, and rarely attains the sharp lacinating type of gall stone colic. The pain, too, in ulcer, bears some relation to the taking of food. The most comfortable moments being those immediately following meals, or when the stomach is completely emptied.

It must be confessed that at times it is impossible to make an exact diagnosis.

A woman, fifty years of age, gave a history of stomach trouble extending over a number of years. One year before I saw her she had vomited a large amount of blood. She had distress after eating, with flatulence, but no vomiting. She could take nothing but liquid nourishment, and even this caused intense pain, except when lying down. There was tenderness midway between the umbilicus and costa arch. Patient was put to bed for three months on milk diet, as I diagnosed the case gastric ulcer. No improvement followed this treatment so it was decided to do a gastro-enterostomy. The stomach and duodenum were found to be normal, but the gall bladder was tightly packed with stones.

In two cases presenting the combination of pain, nausea and vomiting, extending over a number of years, with tnderness in the gall bladder area, no stones were found. In both cases the gall bladder was found distended with thick bile and mucus. Drainage seems to have restored both to perfect health.

In looking over a list of operations, posted daily at the Mayo clinic, I was struck by the fact that nearly every day a case is put down for operation as gall stones, duodenal ulcer or appendicitis. After exhausting every means of arriving at an exact conclusion, they were content to acknowledge that, while it was impossible to definitely state the exact pathological condition, they had surely made a surgical diagnosis, in other words that an operation was demanded to relieve the patient and restore him to health.

SOCIETY MEETINGS.

Annapolis-Kings Medical Society.

A REGULAR meeting of the Annapolis - Kings Medical Society was held in the Court House, Kentville, N. S., September 15th, 1909, at 4 p. m.

Minutes of last meeting read and approved.

Dr. Payzant, chairman of the Committee on Biographical Information, reported progress.

Letter read from the Canadian Association for the Prevention of Tuberculosis, Wm. Moore, Secretary, Ottawa, Canada, regarding the needs of the country in the prevention of tuberculosis, and asking for volunteers to deliver addresses in different parts of the country on the cause and prevention of tuberculosis.

The letter was very ably discussed by Drs. DeWitt, Moore, Balcom and others, and it was resolved that as the Society had been engaged for nearly two years in holding public meetings in the different centres of the two counties for the dissemination of knowledge regarding the cause and prevention of tuberculosis, that the Secretary inform the Association at Ottawa of what had been done and what the Society planned to do in the future along the same lines.

Resolved, That the adoption of the Code of Ethics of the Canadian Medical Association be laid over till the next meeting, and copies of the Code be obtained and sent to all members of the Society.

The afternoon session then adjourned to give members the opportunity of accepting the invitation of the Kentville Lawn Tennis Club to a Garden Party on their grounds.

After enjoying the kind hospitality of the Lawn Tennis Club the members of the Society and ladies were given a drive around the town and visited the Sanatorium, where they were shown the beautiful building and pleasant rooms of this well arranged home for the treatment of tuberculosis, by Dr. W. S. Woodworth and staff.

Evening Session 8 p. m.

Doctors present at the evening session other than regular members:—F. S. L. Ford, of Milton; W. H. McDonald, Rose Bay; James Ross, Halifax; A. Morton, Bedford; C. H. Morris, Windsor; H. K. MacDonald, Halifax, all of whom were given a cordial welcome by President Miller.

The evening programme was then taken up and as Dr. Chisholm, who planned to be present, was unavoidably detained, the secretary read a telegram informing the Society of the fact. The first paper was by Dr. F. S. L. Ford, "Extracts from My Note Book in London." This paper will be published in the News.

Dr. H. K. MacDonald gave the meeting a very pleasant address and cited three very interesting clinical cases, one of chronic cystitis, one of sarcoma of the vagina, one of psoas abscess.

Dr. James Ross spoke of the pleasure he had in meeting with the Society and gave the clinical history of a good many interesting cases. He referred also to the Maritime Medical News, and urged upon all members and the profession generally to encourage the editors of the paper

and its manager by subscribing and remitting promptly.

Drs. W. H. MacDonald, Morris and Morton, gave some very pleasant remarks.

Dr. A. P. Reid, Provincial Health Officer, then read a very comprehensive and instructive paper, "Lessons from the Experience of a Doctor's Life."

The doctor first described the condition of the profession in Ontario (Canada West as it was then) in the 50's of the last century when Eclectics and Homeopaths were struggling for supremacy with a low standard of medical education.

The apprentice system was still in vogue, which with all its faults still had its good points.

He referred to the advantage which a doctor in a country practise had, by bringing out and developing his own self reliance and powers of observation; to the high social status which pertained to the family doctor "ex officio" and his position as adviser in ordinary matters of life as well as health.

He spoke of the great advance in the practise of medicine, and particularly Surgery and Public Health by the epoch making researches of Pasteur, Koch, and the germ theory of disease which re-created serotherapy and placed it on a stable scientific basis.

On Therapeutics and the profession he dwelt very freely, giving illustrations of varied character, and the fraudulent patent medicines which were imposed on the ignorant as well as the various theories which have dominated the medical mind; to pass away and then to be revived. He dwelt freely on the "vis medicatrix naturæ," the doctor's first assistant, and main reliance, and the modern treatment of tuberculosis which obtained in the time of Hippocrates; though the explanation only appeared in our day, with the researches of Koch and Brehmer. He brought out particularly the curative effect of the open air on any form of disease when associated with rational exercise and nutrition. He gave illustrations of the influence of mind on bodily disease and the necessity for the doctor to secure the patient's fullest confidence. That the doctor showed his greatest skill by—

1st—A correct diagnosis.

2nd—Placing the patient under the best conditions for recovery.

3rd—That nature performs the work of cure.

4th—Exercise great care in interfering with natural processes.

5th—Attend to the emunctories.

6th—Regulate the temperature; temperature under 103 F. is often the most necessary means of cure.

7th—*Avoid the Tendency to Death.* No matter what diagnosis we may make, how trivial or how serious may be the lesion; the respiration, circulation, and nervous functions must be carefully observed, for if either fails all effort will be of no avail.

He referred to the present day methods of pharmaceutists which were apt to assume that the body is a chemical entity, and ignore the peculiarities of life which varies so much in individuals and indicates the principles that should guide in the administration of medicine.

Dr. Reid's paper was very ably discussed by Drs. Moore, Woodworth, Balcom and others, after which a hearty vote of thanks was tendered Dr. Reid by the president.

The following resolution was moved by Dr. S. N. Miller, and seconded by Dr. DeWitt:

We, the members of the Annapolis-Kings Medical Society here assembled, consider tuberculosis one of the worst of contagious and infectious disease with which which we have to deal.

We also consider it a curable disease in a large majority of cases under proper hygienic conditions.

We believe that all cases should be isolated as soon as a diagnosis is made, both for the benefit of patients and their families and friends, and that if we intend to fight it to a finish, to stamp it out, we must have such legislation as will give the medical profession authority to isolate each case and place it according to his or their judgment under proper surroundings at home apart from the family, or sent to a tent colony.

Therefore resolved, that we request the Medical Board of Nova Scotia to take the matter up and ask the Government of Nova Scotia to grant us such legislation, and a copy of the resolution be sent to the said Medical Board of Nova Scotia, and a copy to the Legislature.

A vote of thanks was passed thanking the members of the profession of Kentville and the Kentville Lawn Tennis Club for their very kind entertainment.

The invitation of Dr. L. R. Morse to hold the next meeting in Lawrencetown, was accepted, the date being left to the executive committee.

W. F. Read, M. D., *Secretary.*

Canadian Medical Association.

THE forty-third annual meeting will be held at Toronto, June 1st, 2nd, 3rd and 4th, 1910.

February 1st, 1910, has been set as the time limit for submitting papers for the annual meeting. Abstracts of all papers are to be in hands of the General Secretary by April 1st so as to provide for printing and posting same.

President—Adam H. Wright, Toronto.

General Secretary—George Elliott, Toronto.

Treasurer—H. B. Small, Ottawa.

Committee on Arrangements—D. J. Gibb, Wishart (chairman), Allen Baines, J. F. W. Ross, R. W. Bruce Smith, Chas. J. Hastings.

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Programme—E. E. King (chairman), A. H. Wright, D. J. Gibb Wishart, George Elliott, Helen MacMurchy.

Credentials—A. Primrose (chairman), R. J. Dwyer, C. P. Lusk, H. T. Machell, Price Brown.

Surgery—F. N. G. Starr (chairman), I. H. Cameron, Walter McKeown, C. L. Starr, A. H. Perfect, A. B. Wright.

Medicine—H. B. Anderson (chairman), A. McPhedran, John Ferguson, J. S. Hart, A. R. Gordon, B. O'Reilly.

Obstetrics and Gynecology—S. M. Hay (chairman), K. C. McIlwraith, Fred. Fenton, F. W. Marlow, H. E. J. M. MacCallum, Gilbert Royce. Clutterbuck.

Eye, Ear, Nose and Throat—G. R. McDonagh (chairman), R. A. Reeve, J. M. MacCallum, Gilbert Royce.

Pathology—J. J. Mackenzie (chairman), O. R. Mabee.

Pediatrics—Allen Baines (chairman), Wm. Goldie, Jos. Graham.

The President of the American Gynecological Society has appointed a committee to report at the next annual meeting in Washington, on the present status of obstetrical teaching in Europe and America, and to recommend improvements in the scope and character of the teaching of obstetrics in America.

The committee consists of the professors of obstetrics in Columbia University, University of Pennsylvania, Harvard, Jefferson Medical College, John Hopkins University, Cornell, University and the University of Chicago.

Communications from anyone interested in the subject will be gladly received by the chairman of the committee, Dr. B. C. Hirst, 1821 Spruce Street., Philadelphia, Pa.

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GLYCO-THYMOLINE IN GYNECOLOGICAL CONDITIONS.

With Particular Reference to Utero-vaginal Catarrh. By F. L. Newton, M. D., Boston, Mass.

A novel way of using Glyco-Thymoline for vaginal leucorrhea will be of interest. Obtain a few sea sponges of fine soft quality. Cleanse and boil. Draw a thread or cord through one end of same, saturate it with Glyco-Thymoline (full strength) previously placed in a small dish or cup, say half an ounce. The application of the tampon is best made by use of a Ferguson's speculum so placed as to expose or encircle the cervix uteri. With sponge filled with Glyco-Thymoline gently press through the speculum, patient being in lithotomy position with hips raised. If you wish, instruct the patient as to the method. Have her procure the sponges, also a glass

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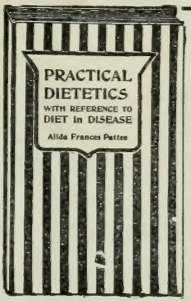

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